

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-007167

Registration District No. 149

Primary Registration District No. 1002 Registrar's No. 985

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

ITEM NO.

2-19-63

1-24-63 to 2-13-63

1-24-63 to 2-12-63

2-10-63

DOCUMENT

BY AFFIDAVIT of attending physician

Medical Certification

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY CLAY	
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY		c. CITY OR TOWN NORTH KAN. CITY	
Length of stay in 1b. 3 Wks.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) 101 EAST 38 ST. NEW HOPE NURSING HOME		d. STREET ADDRESS (If outside, give location) 1004 EAST 21ST AVE.	
3. NAME OF DECEASED (Type or print) First GEORGE Middle WASHINGTON Last WOODY		4. DATE OF DEATH Month FEB. Day 12- Year 1963	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-8-80
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY BUILDER'S STEEL CO	
11. BIRTHPLACE (City and state or country) HARRIS, MD.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME SAMUEL WOODY		13b. MOTHER'S MAIDEN NAME MARTHA CUMMINS	
14. NAME OF HUSBAND OR WIFE LUCINDA C. WOODY		Address NO. KAN. CITY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. MR. F.N. WOODY - 1004 EAST 21ST AVE.	
17. INFORMANT MR. F.N. WOODY - 1004 EAST 21ST AVE.		Interval between onset and death	
18. CAUSE OF DEATH (Enter only one cause per line) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Arteriosclerosis of Coronary Vessels DUE TO (c) Generalized Arteriosclerosis PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III: If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION 12		COUNTY -10- STATE	
21. I attended the deceased from 1-24-63 to 2-15-63 and last saw him alive on 2-18-63 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Dr. H. Thel M.D. (Degree or title)		22b. ADDRESS 4301 Main St. KCMo	
22c. DATE SIGNED 2-13-63		22d. LOCATION (City, town, or county) (State) LAMAR, Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2-15-63	
23c. NAME OF CEMETERY OR CREMATORY LAKE CEMETERY		23d. LOCATION (City, town, or county) (State) LAMAR, Mo.	
24. FUNERAL DIRECTOR D.W. Newcomer's Sons - KAN. CITY, MO		25. DATE RECD. BY LOCAL REG. 2-13-63	
26. REGISTRAR'S SIGNATURE Ruth Long			

USE BLACK INK OR TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John W. Hennick

Licensed Embalmer No. 4848

P. O. Address K.G. 17, Mo.

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.

If this body is not embalmed, fact should be so stated above.

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